TUFTS MEDICARE COMPLEMENT PLAN
DESCRIPTION OF BENEFITS

EFFECTIVE JULY 1, 2018

TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

Introduction:

This booklet contains your Description of Benefits. Part I describes the Group Insurance Commission's ("GIC's") health benefits plan, the Tufts Medicare Complement Plan, which is referred to here as the "Plan." This is a self-funded plan, which means the Group Insurance Commission is responsible for the cost of the Covered Services you receive under it. The GIC has contracted with Tufts Health Plan to offer the Tufts Medicare Complement Plan option and perform certain services for the Plan, such as claims processing and enrollment. We do not, however, insure the Plan benefits or determine your eligibility for benefits under the Plan. This is the Plan's responsibility.

For more information about your coverage under the Tufts Medicare Complement Plan, see **Part I – Tufts Medicare Complement (Medical) Plan**.

Prescription Drug Benefits: Part II explains the GIC's prescription drug benefits plan, which administered under a separate plan by silverScript® Insurance Company. Your benefits, and any requirements you must follow to obtain these benefits, are described in **Part II – Prescription Drug Benefit Plan**.

Member Identification Cards:

Tufts Health Plan and SilverScript® Insurance Company give each Member a separate Member identification card (Member ID).

Tufts Medicare Complement Plan Member ID

Tufts Health Plan gives each Member a Member identification card (Member ID) for this Tufts Medicare Complement Plan. If you have any questions about your Member ID, please call Member Services at 800-870-9488.

Reporting Errors:

When you receive your Member ID, check it carefully. If any information is wrong, call us at 800-870-9488.

Using Your Card:

Your Member ID is important because it identifies your health care plan. Remember to:

- carry your card at all times;
- have your card with you for medical, Hospital and other appointments; and
- show your card to any Provider before you receive health care.

Identifying Yourself as a Tufts Health Plan Member:

When you receive services, you must tell the office staff that you are a Tufts Health Plan Member.

Membership Requirement:

You are eligible for benefits if you are a Member when you receive care. A Member ID alone is not enough to get you benefits. If you receive care when you are not a Member, you are responsible for the cost.

CVS SilverScript® Plan Member ID

You will receive a second Member ID card directly from CVS SilverScript for your Prescription Drug Benefit Plan. If you have questions or would like information about the formulary (list of covered drugs), call the CVS SilverScript customer relations department at 877-876-7214 or visit **gic.silverscript.com**.

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN

705 Mount Auburn Street
Watertown, Massachusetts 02472-1508.

Hours: Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. From October 1st - February 14th, representatives are available seven days a week, 8:00 a.m. to 8:00 p.m.

After hours and on holidays, please leave a message and a representative will return your call the next business day.

IMPORTANT PHONE NUMBERS

Emergency Care:
For routine care you should always call your physician before seeking care. If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room.

Important Note: If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

Medicare:
Contact your local Social Security office or visit the Web site at: **www.medicare.gov**.

Member Services Department:
Call for general questions, including benefit questions, and information regarding eligibility for enrollment and billing. 800-870-9488.

Services for Hearing Impaired Members:
If you are hearing impaired, the following services are provided:

Telecommunications Device for the Deaf (TTY):

If you have access to a TTY phone, call: 711. You will reach Member Services.

Massachusetts Relay (MassRelay): 711.

IMPORTANT ADDRESSES

Appeals and Grievances Department:
If you need to call us about a concern or appeal, contact Member Services at 800-870-9488. To submit your Appeal or Grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9509

WEBSITE

For more information about us and to learn more about the self-service options that are available to you, please see our Web site at: **www.tuftshealthplan.com/gic.**

TRANSLATING SERVICES FOR MORE THAN 200 LANGUAGES

Interpreter and translator services related to administrative procedures are available to assist Members upon request. For information, please call Member Services.

For no cost translation in English, call the number on your ID card.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

Gujarati વિના ખર્ચે ગુજરાતીમાં અનુવાદ માટે, આપના આઈડી કાર્ડમાં દર્શાવેલ નંબર પર કૉલ કરો.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Hindi हिन्दी में बिना मूल्य अनुवाद के लिए, अपने आईडी कार्ड पर दिये गए नंबर पर कॉल करें।

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Khmer **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។**

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotianສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

TTY

Telecommunications Device for the Deaf:
711.

Table of Contents

PART I - TUFTS MEDICARE COMPLEMENT (MEDICAL) PLAN, continued

Chapter 3 – Benefit Schedule and Covered Services, continued:

Chapter 4 – When Coverage Ends:

Chapter 5 – Member Satisfaction Process:

PART I - TUFTS MEDICARE COMPLEMENT (MEDICAL) PLAN, continued

Chapter 6 – Other Plan Provisions:

Appendix A – Glossary of Terms:

PART II - PRESCRIPTION DRUG BENEFIT PLAN
(administered by SilverScript® Insurance Company)

GROUP INSURANCE COMMISSION NOTICES:

PART I:

Tufts Medicare Complement (Medical) Plan

Administered by

Chapter 1: How the Tufts Medicare Complement Plan Works

OVERVIEW

This Tufts Medicare Complement Plan provides coverage to complement your Medicare benefits. The Plan is designed to add to your existing Medicare coverage (Parts A and B of the Original Medicare Program), subject to the terms, conditions, exclusions and limitations of Medicare eligible services.

Under the Plan, coverage is also provided for certain services which are not covered under Medicare. Covered Services, cost sharing, limitations and exclusions are described in Chapter 3: Benefit Schedule and Covered Services.

We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. Your satisfaction with us is important to us. If you have questions, please call Member Services at 800-870-9488. We will be happy to help you.

Benefits under the Plan:
The Plan covers only the services and supplies described as Covered Services in Chapter 3. There are no pre-existing condition limitations under the Plan. You are eligible to use your benefits as of your Effective Date.

Your Description of Benefits:
This book, called your Description of Benefits, will help you find answers to your questions about Tufts Medicare Complement Plan benefits. We certify that you have the right to services and supplies described in this Description of Benefits which are:

- eligible for coverage under Medicare; or
- eligible for coverage under the Plan, when Medically Necessary.

Certain benefits described in this Description of Benefits are consistent with the requirements of Massachusetts law. Medicare is the primary insurer for Medicare-covered services and the Plan is the secondary insurer.

Coverage for Medicare-covered services under the Plan will be subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original Medicare Plan. That coverage is subject to change per Medicare's guidelines. This Description of Benefits is not intended as a full explanation of Medicare's benefits. Information and guidelines established for Medicare by the federal Centers for Medicare and Medicaid Services may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official Medicare Web site at **www.medicare.gov**.

Also, refer to your Medicare handbook for questions pertaining to the Medicare portion of your health care under the Plan.

Note that words with special meanings are defined in the Glossary in Appendix A.

Calls to Member Services:
The Tufts Health Plan Member Services Department is committed to excellent service. Calls to Member Services may, on occasion, be monitored to assure quality service.

Canceling Appointments:
If you must cancel an appointment with any Provider:

- always provide as much notice to the Provider as possible (at least 24 hours), and
- if your Provider's office charges for missed appointments that you did not cancel in advance, the Plan will not pay for the charges.

When You Need Emergency Care

Guidelines for Receiving Covered Emergency Care:
Follow these guidelines when you need Emergency care within the United States.

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.

For information about obtaining Emergency Care and Urgent Care services outside of the United States, please see "Foreign Travel" in Chapter 3.

Eligibility

Subscribers:

- You must meet all of the requirements below to be eligible to enroll in the Plan.
- You must be enrolled in free Medicare Part A and Medicare Part B
- You must be eligible for GIC health coverage as a state or municipal retiree, spouse or dependent. and you must meet the GIC's and the Plan's eligibility rules.
    - Age 65 or older, or
    - Under age 65 and enrolled in Medicare A and B due to disability. If the disability is due to End State Renal Disease (ESRD), you must satisfy the Medicare COB period to be eligible for the plan.

You must not be enrolled in any other Medicare supplement plan.

We may ask you for proof of eligibility. We may also ask you for proof of your continuing eligibility. For instance, we may ask for proof of your continued enrollment in Medicare Part B.

Spouses and Dependents:

Enrollees in the Plan must have Medicare Parts A and B. For a spouse or eligible dependent who is not covered by Medicare, your Group may offer coverage on another plan. Contact the GIC for information on possible coverage for spouses and eligible dependents.

Enrollment:

You must apply to the GIC to enroll in this plan. . The GIC may ask for more information about your eligibility before enrolling you in the Plan.

Effective Date of Coverage:

Upon receipt of your application and required Medicare documentation, the GIC will determine the effective date of enrollment in the plan.

Chapter 3: Benefit Schedule and Covered Services

Important Note: This section provides basic information about your benefits under this plan. Please see the tables below for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums). Please see the current version of your Medicare handbook, which describes the services covered under Medicare Part A and Part B. In addition, see all of the sections in this Tufts Medicare Complement Plan Description of Benefits.

The "Covered Services" section of this chapter describes the health care services and supplies that qualify as Covered Services under this Description of Benefits. Read this section to understand your coverage under this Tufts Medicare Complement Plan option. In addition, this chapter explains the services and supplies limited or excluded under this Description of Benefits. For more information, see the "Limitations on Benefits" and "Exclusions from Benefits" sections at the end of this chapter.

In general, the Plan only provides coverage for benefits eligible for payment under Medicare Parts A and B. As a result, you should see the most recent version of your Medicare handbook. That document will explain to you the benefits, exclusions, and restrictions under your Medicare Parts A and B coverage.

Copayments:
A Copayment is the amount you must pay for certain Outpatient Covered Services before payments are made by the Plan. This amount may be charged to you for an office visit or per day, depending on the type of Covered Service. The amounts of your Copayments for certain Covered Services are listed below in this Benefit Schedule.

Allergy Testing and Treatment:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved allergy testing and treatment.		

Ambulance Services:		
Medicare Pays	**The Plan Pays**	**You Pay***
Medicare benefits in full**, <u>except</u>**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for: • Medicare-approved transportation in an ambulance to an emergency medical facility for treatment of an Accident or for Emergency medical care. • Other Medically Necessary ambulance transportation approved by Medicare.		

Autism Spectrum Disorders – Diagnosis and Treatment:		
Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare, Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** Nothing	**For rehabilitative or habilitative care (including applied behavioral analysis):** **When not covered by Medicare:** Benefits in full, minus a $15 Copayment per visit for services from a Paraprofessional or a $15 Copayment per visit for services from a Board-Certified Behavior Analyst (BCBA). **For prescription medications:** • Nothing. You must have Medicare Part D coverage, which is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **gic.silverscript.com**. **For psychiatric and psychological care:** See "Mental Health and Substance Abuse Services benefit" later in this section. **Therapeutic care:** See "Short Term Rehabilitation Therapy (Physical, Occupational & Speech-Language)" later in this section.	**When covered by Medicare:** • Nothing **When not covered by Medicare:** • Nothing, for rehabilitative or habilitative care. • For services from a Paraprofessional: a $15 Copayment per visit. • For services from a Board-Certified Behavior Analyst: a $15 Copayment per visit. • All charges for all other services.
Tufts Medicare Complement Plan Covered Services		
Coverage is provided, in accordance with applicable law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include: • autistic disorder; • Asperger's disorder; and • pervasive developmental disorders not otherwise specified.		

Coverage is provided, up to the Allowed Charge, for the following Covered Services:

- habilitative or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a Board-Certified Behavior Analyst (BCBA). For more information about these programs, call the Tufts Health Plan Mental Health Department at 800-208-9565.
- Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers.
- psychiatric and psychological care, covered under your "Mental Health and Substance Abuse Services benefit"; and
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your "Short Term Rehabilitation Therapy" benefit.

Notes:

- Prescription medications to treat autism spectrum disorders are covered under Medicare Part D. You will need to enroll in Medicare Part D to receive coverage for these drugs. Medicare Part D coverage is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **gic.silverscript.com**.
- For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- Please call Member Services for information on how to obtain this approval.

Blood Services – Inpatient:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The blood deductible. This deductible is for the first 3 pints of un-replaced blood during a calendar year.	• The blood deductible	• Nothing.
Tufts Medicare Complement Plan Covered Services		
The Plan provides coverage for the Inpatient blood deductible under Medicare Part A. This "deductible" is the cost of the first three pints of blood you use in a calendar year as an Inpatient in a Hospital or Skilled Nursing Facility. Note: The Inpatient blood deductible will only apply to you if the Hospital or Skilled Nursing Facility has to purchase the blood for you for your Inpatient admission. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party. See also "Blood Services – Outpatient" below. You are only responsible for paying one blood deductible under Medicare Part A or Part B per calendar year.		

Blood Services – Outpatient:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The blood deductible.	• The blood deductible.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
The Plan provides coverage for the Outpatient blood deductible under Medicare Part B. This "deductible" is the cost of the first three pints of blood you use in a calendar year as an Outpatient at a Hospital. Note: The Outpatient blood deductible will only apply to you if the Hospital has to purchase the blood for you for your Outpatient services. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party. See also "Blood Services – Inpatient" above. You are only responsible for paying one blood deductible under Medicare Part A or Part B per calendar year.		

Cardiac Rehabilitation Services:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient cardiac rehabilitation services.		

Chemotherapy:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits on an Inpatient basis as described under **Hospital Medical and Surgical Care – Inpatient.** Medicare benefits on an Outpatient basis as described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Inpatient and Outpatient chemotherapy for cancer patients.		

Chiropractor Services:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	…the following charges, a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for manual manipulation of the spine. This benefit must be furnished: (1) by a chiropractor and (2) to correct a subluxation of the spine.		

Diabetic Services and Supplies :		
Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing.	**When covered by Medicare:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare**: • Nothing.	**When covered by Medicare:** • Nothing. **When not covered by Medicare:** • All charges.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for certain Medicare-approved Part B diabetes supplies. These supplies include such items as: blood sugar (glucose) test strips; blood sugar monitors (glucometers); lancet devices and lancets; glucose control solutions for checking test strip and monitor accuracy; therapeutic shoes or inserts for Members with severe diabetic foot disease. Notes: • Part B diabetes supplies are covered under the "Durable Medical Equipment" benefit. • The following diabetes-related drugs and supplies are **not covered** by either Medicare or this Plan: insulin (unless used with an insulin pump); insulin pens; syringes; needles; alcohol swabs; or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs are covered under your separate Prescription Drug Plan. • Your Prescription Drug coverage is Medicare Part D coverage offered under a separate Prescription Drug Plan administered by SilverScript®. For more information, call 877-876-7214 or visit **gic.silverscript.com**.		

Diagnostic Tests, X-rays and Clinical Laboratory Services:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full**, except:** • The Part B Deductible; • The Part B Coinsurance.	…the following charges. • The Part B Deductible; • The Part B Coinsurance.	• Nothing for MRI, CAT scan, and PET scan diagnostic radiological services.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient diagnostic tests, X-rays, and clinical laboratory services.		

Dialysis (Kidney) Services and Supplies:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient maintenance dialysis treatment services and self-dialysis training, as well as certain home dialysis treatment services.		

Durable Medical Equipment and Prosthetic Devices:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, (including some types of breast prostheses after mastectomy), the Plan provides coverage up to the Allowed Charge for Medicare-approved Durable Medical Equipment and prosthetic devices.		

Emergency Room and Urgent Care:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for Emergency Room care, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $50 Copayment for Emergency Room Care (if not admitted): • The Part B Deductible; • The Part B Coinsurance.	• A $50 Copayment for Emergency Room Care (if not admitted).
Medicare benefits in full for Urgent Care services, except: • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services
Once Medicare approves the coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Emergency Room and Urgent Care services within the United States. You do not pay the Copayment if you are admitted as an inpatient to the hospital within 24 hours for the same condition. Note: At the onset of a medical condition that you judge to be an Emergency, go to the nearest emergency medical facility. For more information, see “Guidelines for receiving covered Emergency care” in Chapter 1.

Enteral Formulas, Low Protein Food Products:		
Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare, Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing.	**When covered by Medicare**, • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare: benefits in full** • For certain enteral formulas. • For low protein food products up to $5,000 per calendar year.	**When covered by Medicare**, • Nothing. **When not covered by Medicare:** • Nothing for certain enteral formulas. • All charges for low protein food products after the Plan pays $5,000 in a calendar year.
Tufts Medicare Complement Plan Covered Services		
The Plan provides coverage up to the Allowed Charge for the following formulas and food products: • Enteral formulas for home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; gastrointestinal motility; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids. The Plan covers these formulas in full up to their Allowed Charge. • Food products modified to be low protein when Medically Necessary to treat inherited diseases of amino acids and organic acids. Note that Medicare does not cover these food products. The Plan covers these products up to a maximum of $5,000 per calendar year. You are responsible for paying any additional charges for these products in a calendar year.		

Foreign Travel:		
Medicare Pays	**The Plan Pays**	**You Pay**

• Nothing for Emergency Room and Urgent Care services received outside the United States.	• All expenses Medicare would have paid for if services had been received in the United States,
	  • plus the Medicare Part A and B Deductible and Coinsurance, and
	  • the remainder of charges, minus a $50 Copayment for Emergency Room Care (if not admitted) or a $15 Copayment for an office visit.
		• The appropriate cost share depending on the services rendered:
		  • a $50 Copayment for Emergency Room Care (if not admitted), or
		  • a $15 Copayment for an office visit.

(continued on next page)

Foreign Travel - continued:
Tufts Medicare Complement Plan Covered Services
Medicare generally **does not** cover services that you receive while traveling outside of the United States and its territories. For more information on this topic, please refer to your Medicare handbook. For Emergency Room and Urgent Care services that **Medicare would have covered** if you received them in the United States, the Plan provides benefits for both: • the Covered Services listed in this Description of Benefits; and • the benefits that Medicare normally provides that are listed in this Description of Benefits. Note: The Plan will **not** pay for any services if you establish residency outside of the United States or its territories.

Home Health Care:		
Medicare Pays	**The Plan Pays**	**You Pay**
For Medicare covered home visits, Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved home health care services. Note: The Plan also provides coverage up to the Allowed Charge for Durable Medical Equipment required as part of Medicare-approved home health care services. This coverage is provided once Medicare provides benefits for this equipment.		

Hospice Care:		
Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare, • Medicare benefits in full for most services. **When not covered by Medicare** • Nothing.	**When Medicare does not provide benefits in full**, • The difference between the amount Medicare pays and the Allowed Charge. **When not covered by Medicare** • Covered Services in full.	**When covered by Medicare,** • Nothing. **When not covered by Medicare** • Nothing.
Tufts Medicare Complement Plan Covered Services		
If Medicare does not provide either full benefits or any benefits for hospice care services, the Plan provides coverage up to the Allowed Charge for the following hospice care services required for a terminally-ill person (a person with a life expectancy of six months or less) under Massachusetts law: • the following services when they are either provided or arranged by a hospice care provider: physician services; nursing care provided by or supervised by a registered professional nurse; social work services; volunteer services; home health aide services; counseling services; Durable Medical Equipment; and drugs; • respite care (care for the terminally ill person to provide relief to the family or other person providing primary care to that person); and • bereavement counseling services for the Member's family.		

Hospital Medical and Surgical Care – Inpatient:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full in a **general Hospital facility per Benefit Period**, **except**: • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days.	**Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for day 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days; • Covered Services in full up to an additional 365 days per lifetime after Medicare benefits are used up.	**Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve Days; • Nothing for Covered Services up to an additional 365 days per lifetime after Medicare benefits are used up; • Then, all charges.
Medicare benefits in full for **physician and other professional provider services**, **except**: • The Part B Deductible • The Part B Coinsurance	• The Part B Deductible; • The Part B Coinsurance.	• Nothing
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for all Medicare-approved Inpatient days during a Benefit Period. This Tufts Medicare Complement Plan coverage is provided for: • the 1st 60 days of a Benefit Period; • the 61st through 90th day of a Benefit Period; and • the 60 lifetime Medicare Reserve Days. Once you have used up all of your Medicare Reserve Days, the Plan provides coverage up to the Allowed Charge for an additional 365 lifetime Inpatient days. These additional days are only covered for semi-private room and board charges. **Note**: Neither the Plan nor Medicare covers private duty nursing services.		

Hospital Medical and Surgical Care - Outpatient (including Ambulatory Surgical Centers):		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full in a **general Hospital facility or Ambulatory Surgical Center**, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	Nothing.
Medicare benefits in full for **physician and other professional provider services**, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient Hospital and medical care including: physician services; Outpatient medical services and supplies; physical and speech therapy; diagnostic tests; and Durable Medical Equipment. Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient surgical care provided in a Medicare-approved facility (for example, a general Hospital or an ambulatory surgical center).		

Human Organ Transplants:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits on an Inpatient basis as described under **Hospital Medical and Surgical Care – Inpatient.** Medicare benefits on an Outpatient basis as described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved human organ transplants. • Medicare Part A provides coverage under certain conditions and only at Medicare-approved facilities for transplants of: the heart; lung; kidney; pancreas; intestine; and liver. • Medicare Part B provides coverage for cornea and bone marrow transplants. For more information about this coverage under Medicare Part A and Part B, see your Medicare handbook or contact Medicare.		

<table>
<tr><th colspan="3">Medical Care Outpatient Visits by a Physician or Covered Practitioner (Non-physician):</th></tr>
<tr><th>Medicare Pays</th><th>The Plan Pays</th><th>You Pay</th></tr>
<tr><td>Medicare benefits in full, except:
• The Part B Deductible;
• The Part B Coinsurance.</td><td>The following charges, minus a $15 Copayment per visit:
• The Part B Deductible;
• The Part B Coinsurance.</td><td>• A $15 Copayment per visit.</td></tr>
<tr><th colspan="3">Tufts Medicare Complement Plan Covered Services</th></tr>
<tr><td colspan="3">Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved medical care used to diagnose or treat an illness or injury such as:
• office, home, or clinic visits;
• medical nutrition therapy services;
• hormone replacement therapy for peri- and post-menopausal women;
• follow-up medical care following an Accidental injury or an Emergency.

<u>Note</u>: This benefit includes coverage for psychopharmacological services and neuropsychological assessment services.</td></tr>
</table>

Mental Health and Substance Abuse Services:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for **Inpatient stay in a general Hospital, except:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days.	**Inpatient stay in a general Hospital** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days; • Covered Services in full up to an additional 365 days per lifetime** after Medicare benefits are used up.	**Inpatient stay in a general Hospital** **Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve Days; • Nothing for Covered Services up to an additional 365 days per lifetime** after Medicare days are used up; • Then, all charges.
Medicare benefits in full for **Inpatient stay in a mental Hospital, except:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days. Note: Medicare benefits in a mental hospital are limited to 190 days per lifetime.	**Inpatient stay in a mental Hospital** **Per Benefit Period:** • The Part A Deductible for day 1-60; • The Part A Coinsurance for day 61-90; • The Part A Coinsurance for 60 lifetime Reserve Days; • Covered Services in full up to 120 additional days per benefit period in a mental hospital, less any days in a mental hospital already covered by Medicare or the Plan in that benefit period or calendar year.	**Inpatient stay in a mental Hospital** **Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve Days; • Covered Services up to 120 days per benefit period in a mental hospital; • Then, all charges.

(continued on next page)

Mental Health and Substance Abuse Services - continued:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for **Inpatient physician and other covered professional mental health provider services** for as many days as Medically Necessary, **except:** • The Part B Deductible; • The Part B Coinsurance.	**Inpatient physician and other covered professional mental health provider services** covered by Medicare and the Plan for as many days as Medically Necessary in a general Hospital: • The Part B Deductible; • The Part B Coinsurance; • Covered Services in full for as many days as Medically Necessary in a general Hospita and up to 120 additional days per benefit period in a mental Hospital when covered only by the Plan.	**Inpatient physician and other covered professional mental health provider services** • Nothing for as many days as Medically Necessary.
Medicare benefits in full for Medically Necessary **Outpatient treatment, <u>except</u>:** • The Part B Deductible; • The Part B Coinsurance.	**Outpatient treatment** for as many visits as Medically Necessary …the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance. • Covered Services in full when provided only by the Plan, minus a $15 Copayment per visit.	**Outpatient treatment** for as many visits as Medically Necessary: • A $15 Copayment per visit for Medicare and Plan benefits for as many visits as Medically Necessary; • A $15 Copayment per visit when covered only by the Plan.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient services provided by a mental health care provider. If Medicare does not provide coverage, the Plan provides coverage up to the Allowed Charge for Inpatient services provided by a physician specializing in psychiatry, a psychologist, a licensed independent clinical social worker, a clinical specialist in psychiatric and mental health nursing, or a licensed mental health counselor. The Plan provides this coverage for as many visits as are Medically Necessary.

<u>Note</u>: Coverage of other, non-mental health treatment of autism and autism spectrum disorders is described under “Autism spectrum disorders – diagnosis and treatment” earlier in this chapter.

The Plan provides coverage up to the Allowed Charge or Medicare-approved Inpatient Mental Health and Substance Abuse Services:

- Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for all Medicare-approved Inpatient days during a Benefit Period. The Plan coverage is provided for:
  - the 1st 60 days of a Benefit Period;

- the 61st through 90th day of a Benefit Period; and
- the 60 lifetime Reserve Days.

Once you have used up all of your Reserve Days, the Plan provides coverage up to the Allowed Charge for an additional 365 lifetime Inpatient days. These additional days are only covered for semi-private room and board charges.

Note: These limits also apply to all other Inpatient stays. For more information, see the benefit description for "Hospital Medical and Surgical Care - Inpatient" earlier in this chapter.

The Plan provides coverage up to the Allowable Charge under this benefit for:

- Up to 120 days per Benefit Period. This may occur when your Inpatient days are covered by Medicare or the Plan during a Benefit Period (or in the same calendar year).
- Up to a total of 365 lifetime Inpatient days.

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient services provided by a physician specializing in psychiatry or a psychologist. If Medicare does not provide coverage, the Plan provides coverage up to the Allowed Charge for Inpatient services provided by a physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing.

Intermediate Mental Health Care Services:

In certain instances, you may need Covered Services that are more intensive than Outpatient services (but not requiring a 24-hour Inpatient Hospital admission). Both Medicare and the Plan cover these intermediate mental health care services. As a result, Medicare will decide whether this care is Medically Necessary for you. These services include, but are not limited to: intensive Outpatient programs; acute residential; and partial Hospital programs.

**The 365 additional lifetime days are combined for all Inpatient stays in general and mental Hospitals.

Oxygen and Equipment:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for: • the rental of oxygen equipment; and • oxygen contents and supplies for the delivery of oxygen.		

Podiatry:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance, minus a $15 Copayment per visit.	• A $15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for: • Treatment of injuries and diseases of the feet (such as hammer toes and spurs). • Routine foot care* for members with certain medical conditions affecting the lower limbs. *For information about foot care related to diabetes, see "Diabetes Services and Supplies" in this Benefit Schedule.		

Prescription Drugs – Limited Outpatient Drug Coverage under Medicare Part B:		
Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare, Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	**When covered by Medicare,** • The Part B Deductible; • The Part B Coinsurance.	**When covered by Medicare,** • Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a limited number of Outpatient prescription drugs covered under Medicare Part B. Some examples include certain drugs in the following categories: • osteoporosis drugs; • injectable drugs given by a licensed medical practitioner; and • oral anti-nausea drugs. For more information about this Part B benefit, see your Medicare handbook or contact Medicare. Note: This Plan **does not** pay for most prescription drugs. You pay the full cost for most prescription drugs. In order to receive the full prescription drug benefits available through Medicare, you need to enroll in the GIC's Prescription Drug Plan. That Medicare Part D coverage is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **gic.silverscript.com**.		

Preventive Care – Annual Prostate Cancer Screenings:		
Medicare Pays	**The Plan Pays**	**You Pay**

Medicare benefits as follows for annual prostate cancer screenings:
• Full benefit for annual Prostate-Specific Antigen (PSA) test.
• Annual digital rectal exam covered, subject to
  • The Part B Deductible;
  • The Part B Coinsurance.
	• Nothing.
	• The Part B Deductible;
	• The Part B Coinsurance.
		• Nothing.
		• Nothing.

Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for the following routine prostate cancer screenings: • Digital rectal exam: one exam per year for Members age 50 or older. • PSA blood test: one test per year for Members age 50 or older. Note: The Plan may also provide coverage up to the Allowed Charge for additional prostate cancer screenings determined by Medicare to be Medically Necessary.		

Preventive Care – Annual Screening Mammograms:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for annual screening mammogram.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for mammograms as follows: • One baseline mammogram for a Member between ages 35 and 39. • One routine mammogram each calendar year for a Member age 40 or older. Note: The Plan also provides coverage up to the Allowed Charge for Medically Necessary diagnostic mammograms. For more information, see “Laboratory Tests, X-rays, and Other Diagnostic Tests” earlier in this chapter.		

Preventive Care – Annual Wellness Exam:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for an annual wellness exam. Note: This benefit applies in years following the initial Welcome to Medicare physical exam.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Medicare provides coverage for an annual wellness exam. This benefit applies in years following the initial one-time "Welcome to Medicare" physical exam.		

Preventive Care – Bone Mass Density Testing:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for screening bone mass density testing.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved bone mass density testing. This testing is provided to: identify bone mass; determine bone quality; or detect bone loss. For more information, see your Medicare handbook or contact Medicare.		

Preventive Care – Cardiovascular Screening:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for routine cardiovascular screening.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for screenings once every five years to test a Member's cholesterol, lipid, and triglyceride levels.		

Preventive Care – Colorectal Cancer Screenings:		
Medicare Pays	**The Plan Pays**	**You Pay**

Medicare benefits as follows for routine colorectal cancer screenings:
• Full benefits for Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, and DNA based colorectal screening.
• Barium enema covered, subject to:
  • The Part B Deductible;
  • The Part B Coinsurance.
	• Nothing.
	
	• The Part B Deductible;
	• The Part B Coinsurance.
		• Nothing.
		
		• Nothing.

Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for the following routine colorectal cancer services: • Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT) : one test per year for Members age 50 or older • Flexible Sigmoidoscopy: one test every four years for Members age 50 or older. • Colonoscopy: one test every two years for Members determined by Medicare to be at high risk for developing colorectal cancer. • Colonoscopy: one test every ten years for Members determined by Medicare not to be at high risk of colorectal cancer, but not within four years of a screening sigmoidoscopy • Barium Enema: one test every four years for Members age 50 or older • DNA based colorectal screening every three years.		

Preventive Care – Diabetes Self-Management Training:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for diabetes self-management training, except: • The Part B Deductible; • The Part B Coinsurance.	…the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A 15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat: insulin-dependent diabetes; non-insulin-dependent diabetes; or gestational diabetes.		

Preventive Care – Family Planning:		
Medicare Pays	**The Plan Pays**	**You Pay**
For family planning: • Nothing.	• Benefits in full as required by state mandate.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
The Plan provides coverage up to the Allowed Charge for the following family planning services: • Consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United State Food and Drug Administration (USFDA). • The injection of birth control drugs, including a prescription drug obtained from the Provider during an office visit. • Genetic counseling. • Insertion of implantable contraceptives, including levonorgestrel implants. Coverage includes the implant system as well. • Intrauterine devices (IUDs), diaphragms, and any other USFDA-approved contraceptive methods, when these contraceptives are obtained from the Provider during an office visit.		

Preventive Care – Glaucoma Testing:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for glaucoma testing, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one glaucoma test every 12 months. This coverage is for Members that Medicare decides to be at high risk for glaucoma.		

Preventive Care – Medical Nutrition Therapy:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for Medical Nutrition Therapy	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved medical nutritional therapy services for Members with diabetes or kidney disease.		

Preventive Care – Medicare Diabetes Prevention Program (MDPP):		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for the Medicare Diabetes Prevention Program	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
MDPP services are covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavioral change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.		

Preventive Care – Pelvic and Clinical Breast Exams and Routine Cytology Exam (Pap Smear):		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for pelvic, pap smear, and clinical breast exams	• Nothing.	• Nothing.
Medicare benefits in full for a Pap smear test every two years.	• In full for an annual routine Pap smear test each calendar year (covered in years when Medicare benefits do not cover this test).	• Nothing.
Tufts Medicare Complement Plan Covered Services		
<u>Medicare-covered exams and tests:</u> Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one gynecological exam (including a routine Pap smear) every two years. This coverage is provided every year for a Member that Medicare determines to be at high risk for developing cervical or vaginal cancer. <u>Non-Medicare-covered exams and tests:</u> If Medicare does not provide coverage for a routine cytological exam (pap smear) per calendar year, the Plan provides full coverage up to the Allowed Charge for that exam.		

Preventive Care – for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for screening for lung cancer with low dose computed tomography (LDCT)	• Nothing	• Nothing

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for screening for lung cancer with low dose computed tomography (LDCT)

Note: For qualified Members, a LDCT is covered every 12 months.

Eligible Members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

For LDCT lung cancer screenings after the initial LDCT screening: the Member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

Note: There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Preventive Care – Smoking and Tobacco Use Cessation Counseling:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for a Medicare approved smoking cessation program for members who have not been diagnosed with an illness caused or complicated by tobacco use.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a Medicare-approved smoking cessation program. This coverage includes up to 8 face-to-face visits in a 12-month period.

Preventive Care – "Welcome to Medicare" Visit (One Time):		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for a one-time physical exam within 12 months after Part B coverage begins.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time "Welcome to Medicare" visit. Note: Medicare covers this exam when a Member receives it within 12 months after enrolling in Medicare Part B.		

Radiation and X-ray Therapy:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for radiation and x-ray therapy.		

Second Opinions:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for: (1) an Outpatient second opinion regarding your medical care; or (2) a second surgical opinion. Coverage may also be provided for a third opinion, when the second opinion is different from the initial opinion.		

Short Term Rehabilitation Therapy (Physical, Occupational & Speech-Language):		
Medicare Pays	**The Plan t Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	…the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient short-term rehabilitation therapy. This coverage includes: physical therapy; occupational therapy; and speech therapy. Also, the Plan provides coverage for Medically Necessary services required to diagnose and treat speech, hearing, and language disorders.		

Skilled Nursing Facility Services:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits **per Benefit Period:** • in full for days 1-20; • In full for days 21-100, <u>except</u> for the Part A Coinsurance; • Nothing for days 101 – 365; • Nothing for days 366 and beyond.	**Per Benefit Period:** • Nothing. • The Part A Coinsurance. • Nothing.	**Per Benefit Period:** • Nothing. • Nothing. • All costs.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Skilled Nursing Facility services. This coverage is provided through the 100th day in a Benefit Period. After that, the Plan provides coverage as follows: <u>Note:</u> Medicare and the Plan both provide coverage for Skilled Nursing Facility services, when a Member's Inpatient stay in such a facility meets Medicare's rules. These rules include Medicare's requirement that the Member: (1) be an Inpatient in a Hospital for at least three days; and then (2) transfer to the Skilled Nursing Facility within 30 days after leaving that Hospital.		

Surgery as an Outpatient:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	As described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Outpatient.**
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient surgery.		

Women's Health and Cancer Rights Act Coverage:		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits on an Inpatient basis as described under **Hospital Medical and Surgical Care – Inpatient.** Medicare benefits on an Outpatient basis as described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**	As described under **Hospital Medical and Surgical Care – Inpatient.** As described under **Hospital Medical and Surgical Care – Outpatient.**
Tufts Medicare Complement Plan Covered Services		
The Plan provides coverage up to the Allowed Charge for breast reconstruction in connection with a mastectomy. This includes the following services: • reconstruction of the breast affected by the mastectomy; • surgery and reconstruction of the other breast to produce a symmetrical appearance, and; • prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).		

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare):		
Medicare Pays nothing for the following Covered Services provided by the Plan:	**The Plan Pays**	**You Pay**
• Routine physical exam: covered for one exam per calendar year	All charges.	Nothing.
• Routine hearing exam: covered for one exam per calendar year	All charges for one annual exam, minus a $15 Copayment for the exam.	A $15 Copayment for the exam.
• Routine eye exam (including refraction): covered for one exam every 24 months	All charges for one exam every 24 months, minus a $15 Copayment for the exam.	A $15 Copayment for the exam.
• Fitness Benefit	All combined charges up to a maximum benefit of $150 per calendar year.	All costs, after the maximum benefit of up to $150 per calendar year is reached.
• Lead screenings for Children, in accordance with Massachusetts law.	All charges.	Nothing.

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare):		
Medicare Pays nothing for the following Covered Services provided by the Plan:	**The Plan Pays**	**You Pay**
• Hearing aids for Members age 22 and over: Covered up to a maximum benefit of $1,700 in each 24-month period. Note: This $1,700 maximum is reached as follows in the 24-month period: • The Plan pays the first $500. • Then, the Plan pays 80% of the next $1,500 towards the cost of the hearing aid.	The first $500 of a covered hearing aid, and then 80% of the next $1,500. Coverage is provided up to a maximum benefit of $1,700 in each 24-month period.	After the first $500 paid by the Plan, 20% of the next $1,500 for a covered hearing aid. You also pay any balance over that $1,500. You also pay all costs, after the maximum benefit of $1,700 in each 24-month-period is reached.
• Hearing aids for Members age 21 and under, in accordance with Massachusetts law. See Covered Services below.	All charges for each covered hearing aid. Coverage is provided up to a maximum benefit of $2,000 per ear every 24 months.	All costs, after the maximum benefit of $2,000 per ear every 24 months.
• Coronary Artery Disease Program. A Coronary Artery Disease secondary prevention program assists Members with documented Coronary Artery Disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when Medically Necessary, at designated programs to Members who meet the clinical criteria established for this program. For more information about this program, Members should call Member Services at 800-870-9488.	90% of charges for all Covered Services.	10% of charges for all Covered Services.

Medicare Pays nothing for the following Covered Services provided by the Plan:	The Plan Pays	You Pay*
• Scalp hair prostheses worn for hair loss suffered due to the treatment of any form of cancer or leukemia.	All charges up to a maximum benefit of $350 per calendar year.	All costs, after the maximum benefit of up to $350 per calendar year is reached.
• Cleft lip or cleft palate treatment and services for children, in accordance with Massachusetts law. See Covered Services below.	All charges, minus the following charges for oral surgery covered under this benefit: • A $15 Copayment per office visit. • A $50 Copayment per Emergency Room visit. The Plan pays all charges for covered Inpatient and Day Surgery services.	The following charges for oral surgery covered under this benefit: • A $15 Copayment per office visit. • A $50 Copayment per Emergency Room visit. Nothing for covered Inpatient and Day Surgery services.
• Outpatient substance services for medication-assisted treatment, including methadone maintenance	All charges.	Nothing.
• Medically Necessary diagnosis and antibiotic treatment of chronic Lyme disease. • Long-term antibiotic tre**atm**ent of chronic Lyme disease. Treatments for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, Experimental or Investigative. <u>Note</u>: Long-term antibiotic treatment of chronic Lyme disease covered through your Prescription Drug Benefit are provided under the separate Medicare Plan D plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **<u>gic.silverscript.com</u>**.	All charges, minus a $15 Copayment per visit.	A $15 Copayment, depending on services received.

Tufts Medicare Complement Plan – Additional Benefits and Reimbursements

Routine Vision Exams:
The Plan covers one routine vision exam every 24 months to find out if you need corrective lenses, when the exam is furnished by any licensed ophthalmologist or optometrist.

Eyeglasses or contact lenses:
Members can receive 35% off the retail price of frames, and discounted lenses and lens options, with the purchase of a complete pair of eyeglasses or prescription sunglasses from a participating EyeMed Vision Care provider. EyeMed also offers Members a contact lens replacement program; 20% off the retail price of nonprescription sunglasses; and 15% off the retail price (or 5% off the promotional price) of LASIK and PRK laser vision correction.

Cleft lip or cleft palate treatment and services for Children:

In accordance with applicable law, the following services are covered for Children under the age of 18 when services are prescribed by the treating physician or surgeon, and that Provider certifies that the services are Medically Necessary and required because of the cleft lip or cleft palate.

- Medical and facial surgery: This includes surgical management and follow-up care by plastic surgeons;
- Oral surgery: This includes surgical management and follow-up care by oral surgeons;
- Dental surgery or orthodontic treatment and management;
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy
- Speech therapy and audiology services;
- Nutrition services.

Hearing aids for Members age 21 and under:

In accordance with applicable law, the following services are covered for Members age 21 and under upon written statement from that Member's treating physician that the hearing aids are necessary regardless of the cause:

- One hearing aid per hearing impaired ear per prescription change up to $2,000 every 24 months.
- Hearing aid evaluations;
- Fitting and adjustment of hearing aids;
- Supplies, including ear molds.

Hearing aids for Members age 22 and over:

The following services are covered for Members age 22 and over upon written statement from that Member's treating physician that the hearing aids are necessary regardless of the cause:

- One hearing aid per hearing impaired ear per prescription change up to a maximum benefit of $1,700 every 24 months.
- Hearing aid evaluations;
- Fitting and adjustment of hearing aids;
- Supplies, including ear molds.

Tufts Medicare Complement Plan – Additional Benefits and Reimbursements

Fitness Reimbursement:

Covers up to a total of $150 per calendar year towards membership fees and/or exercise classes for a Member enrolled in a qualified health club or fitness facility. Important notes about this benefit:

- A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs and community fitness centers.
- This benefit does not cover fees paid to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers; gymnastics facilities; country clubs; social clubs; facilities providing only yoga, Pilates, aerobics, golf, tennis, swimming or other sports activity.
- To obtain up to the $150 Fitness reimbursement, please submit a Fitness Benefit claim form along with an itemized bill from the qualified facility and paid receipts. Call Member Services to request a claim form or go to our website at **www.tuftshealthplan.com/gic**. Send the completed claim form, along with the paid receipts, to Member Services at the address shown on the claim form.
- Reimbursement requests must be received by Tufts Health Plan by no later than March 31st of the following year.
- For more information about this benefit, call Member Services.

Limitations on Benefits

Dental Care Services:
Dental care is not covered under this Plan. Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, root canals, tooth extractions and dentures. However, if you need to have Emergency or complicated dental procedures, Medicare Part A may pay for your Hospital stay even when Medicare does not cover the actual dental care services. For more information, see your Medicare handbook or contact Medicare.

Exclusions from Benefits

List of Exclusions:

The Plan will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not Medically Necessary.
- A service, supply or medication which is not a Covered Service.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- Custodial care.
- Services related to non-covered services.
- A drug, device, medical treatment, or procedure (collectively "treatment") that is experimental or investigative.
    - This exclusion does not apply to the following services, as per Massachusetts law:
        - long-term antibiotic treatment of chronic Lyme disease when administered as described under "Medically Necessary diagnosis and antibiotic treatment of chronic Lyme disease" earlier in this Chapter 3 (for drugs administered under a separate Medicare Part D Prescription Drug Plan administered by CVS SilverScript®),
        - bone marrow transplants for breast cancer, or
        - patient care services provided pursuant to a qualified clinical trial.
    - If the treatment is experimental or investigative, we will not pay for any related treatments which are provided to the Member for the purpose of furnishing the experimental or investigative treatment.
- Drugs, medicines, materials or supplies for use outside the Hospital or any other facility, except as described earlier in this chapter. Coverage for prescription drugs is provided under the separate Medicare Part D Prescription Drug Plan administered by CVS SilverScript®.
- Laboratory tests ordered by a Member (online or through the mail), even if performed in a licensed laboratory.
- The following exclusions apply to services provided by the relative of a Member:
    - Services provided by a relative who is not a Provider are not covered.
    - Services provided by an immediate family member (by blood or marriage), even if the relative is a Provider, are not covered.
    - If you are a Provider, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).

- Services, supplies, or medications required by a third party which are not otherwise medically necessary. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a Covered Service.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided earlier in this chapter.

  Note: Breast reconstruction is covered when following a Medically Necessary mastectomy, as described in "Women's Health and Cancer Rights Act Coverage" earlier in this chapter.
- Human organ transplants, except as described earlier in this chapter.
- Any service, program, supply, or procedure performed in a non-conventional setting including, but not limited to: spas/resorts; educational, vocational or recreational settings; Outward Bound; or wilderness, camp or ranch programs, even if performed or provided by a licensed Provider (including , but not limited to, mental health professionals, nutritionists, nurses or physicians). Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services, and nutritional counseling.
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries). Internet and modem connection/access including, but not limited to Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- Hearing aids, except as described in Chapter 3: "Benefit Schedule and Covered Services."
- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet, except:
  - This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the Member's treating doctor, and the shoes and inserts:
    - are prescribed by a Provider who is a podiatrist or other qualified doctor; and
    - are furnished by a Provider who is a podiatrist, orthotist, prosthetist, or pedorthist.
  - This exclusion also does not apply to routine foot care for Members diagnosed with diabetes.
- All Non-Conventional Medicine services, provided independently or together with conventional medicines, and all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine.

- Infertility services, infertility medications and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to:
    - Experimental infertility procedures
    - The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile Member; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a Member.
        - A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.
        - A gestational carrier is a surrogate with no biological connection to the embryo/child.
- Reversal of voluntary sterilization.
- Sperm or embryo cryopreservation.
- Donor recruitment fee for donor egg or donor sperm.
- Donor sperm and associated laboratory services.
- Costs associated with donor recruitment and compensation.
- Infertility services that are necessary for conception as a result of voluntary sterilization or after an unsuccessful reversal of a voluntary sterilization.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services and supplies related to reversal of voluntary sterilization.

Chapter 4: When Coverage Ends

Overview

Introduction:
This chapter tells you when coverage ends.

Reasons Coverage Ends:
Coverage ends when any of the following occurs:

- You lose eligibility because you no longer meet the GIC's eligibility rules.
- you lose eligibility because:
  - you no longer are enrolled in Medicare Parts A and B;
  - you choose to drop coverage; or
  - material misrepresentation.

When a Member is No Longer Eligible

Loss of Eligibility:
Your coverage ends on the date you no longer meet the GIC's eligibility rules, or no longer are enrolled in Medicare Parts A and B.

> **Important Note:** Your coverage will terminate retroactively to the date you are no longer eligible for coverage.

You Choose to Drop Coverage:
You may cancel your coverage within 60 days of a qualifying event or during the GIC's Annual Enrollment Period. Contact the Group Insurance Commission at 617-727-2310 or visit **www.mass.gov/gic** for more information.

Membership Termination for Material Misrepresentation

Policy:
Your coverage may be terminated for making a material misrepresentation to us. If your coverage is terminated for this reason, we may not allow you to re-enroll for coverage with us under any other plan (such as individual plan or an employer group plan).

Acts of Material Misrepresentation:
Examples of material misrepresentation include:

- false or misleading information on your application;
- receiving benefits for which you are not eligible;
- allowing someone else to use your Member ID; or
- submission of any false paperwork, forms, or claims information.

Date of Termination:
If the Plan terminates your coverage for material misrepresentation, your coverage will end as of your Effective Date or a later date chosen by the Plan.

Payment of Claims:
The Plan will pay for all Covered Services you received between:

- your Effective Date; and
- your termination date, as chosen by the Plan. The Plan may retroactively terminate your coverage back to a date no earlier than your Effective Date.

The Plan may use any contributions to coverage you paid for a period after your termination date to pay for any Covered Services you received after your termination date.

If the contributions you paid are not enough to pay for that care, the Plan may, at its option:

- pay the Provider for those services and ask you to pay the Plan back; or
- not pay for those services. In this case, you will have to pay the Provider for the services.

If the contribution to coverage is more than is needed to pay for Covered Services you received after your termination date, the Plan will refund the excess to the GIC.

Termination of the Group Contract

End of Tufts Health Plan's and the GIC's Relationship:
Coverage will terminate if the relationship between the Group Insurance Commission and Tufts Health Plan ends for any reason, including:

- the GIC's contract with us terminates;
- the GIC fails to pay contributions for Member coverage on time;
- we no longer offer this Tufts Medicare Complement Plan to the GIC; or
- we stop operating.

Important Notes about Appeals and Grievances:

- In many instances, we will ask you to direct your initial concern to Medicare. This is because Medicare will make the primary determination on your health care benefits. Information is available by contacting your local Social Security office or on the official Medicare Web site at: **www.medicare.gov.**
- The Member Satisfaction Process described below applies to you when we determine that a service is Medically Necessary under this Plan only (and **not** under Medicare).

Tufts Health Plan Member Appeals Process

Tufts Health Plan ("Tufts HP") has a Member Satisfaction Process to address your concerns promptly about a service under this Plan only (and **not** under Medicare). This process addresses:

- Internal Inquiry
- Member Grievance Process
- Appeals:
  - Internal Member Appeals, and
  - Expedited Appeals.

All grievances and appeals should be sent to Tufts HP at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9508

All calls should be directed to the Member Services Department at 800-870-9488**.** Alternatively, you may submit your grievance or appeal at the address listed above.

Internal Inquiry
Call the Member Services Department at 800-870-9488 to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Specialist that you are not satisfied with the response you have received from Tufts HP, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Member Appeals Process, continued

Grievances

A grievance is a formal complaint about actions taken by Tufts HP or a Provider. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact Tufts HP as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a Tufts HP Member Specialist, who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- Your name and address
- Your Member ID number
- A detailed description of your concern (including relevant dates, any applicable medical information, and Provider names,)
- Any supporting documentation.

Note: The Member Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal Member Appeals" section below.

Administrative Grievance

An administrative grievance is a complaint about a Tufts HP employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- If you file your grievance in writing, Tufts HP will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concern within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- Tufts HP will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended upon mutual written agreement between you or your authorized representative and Tufts HP.

Member Appeals Process, continued

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received from a Provider. If you have concerns about your medical care, you should discuss them directly with your Provider. If you are not satisfied with your Provider's response or do not wish to address your concerns directly with your Provider, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you written confirmation of our understanding of your concerns within 48 hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within 30 calendar days of receipt. The review period may be extended up to an additional 30 days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this Description of Benefits (or subsequent updates) or for coverage that was denied based on medical necessity determinations are reviewed as appeals through Tufts Health Plan's Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances". Tufts HP encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- Your complete name and address;
- Your ID number and suffix;
- A detailed description of your concern; and
- Copies of any supporting documentation.

You may also submit your appeal in person at the address listed at the beginning of this chapter.

(continued on next page)

Member Appeals Process, continued

Internal Member Appeals, continued

(ii) Within forty-eight (48) hours following Tufts Health Plan's receipt of your verbal or written appeal, a Tufts Health Plan Appeals and Grievances Analyst will send you an acknowledgment letter, a summary of our understanding of your concerns, and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal.

Once you have signed and returned the authorization for the release of medical and treatment information to Tufts Health Plan, an Appeals and Grievances Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to Tufts Health Plan within 30 calendar days of the day you requested a review of your case, Tufts HP may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The Tufts Health Plan Benefits Committee will review appeals concerning specific benefits and exclusions and make determinations. If your appeal involves an adverse determination (medical necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, performs the procedure, or provides the treatment that is under review. The medical director and/or practitioner will not have previously reviewed your case.

(iv) The Appeals and Grievances Analyst will notify you in writing of the Committee's decision within no more than 30 calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, unless you request otherwise. A determination of claim denial will set forth:

- Tufts Health Plan's understanding of the request;
- The reason(s) for the denial;
- The specific contract provisions on which the denial is based
- The clinical rationale for the denial, if the appeal involves a medical necessity determination.

Tufts Health Plan maintains records of each inquiry made by a Member or by that Member's designated representative.

Expedited (Fast) Appeals

Tufts HP recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. Tufts HP will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your treating Provider (the practitioner responsible for the treatment or proposed treatment), you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited (fast) appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in the same (or in a similar) specialty that typically manages the medical condition, performs the procedure or provides the treatment that is under review. This Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within two (2) business days, but not later than 72 hours (whichever is less) after Tufts HP's receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

Member Appeals Process, continued

External Review
For certain types of claims, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan
Medicare Complement Plan
Attn: Appeals & Grievances Department
705 Mt. Auburn Street
Watertown, MA 02471-9193

Fax: 617-972-9509

In some cases, Members may have the right to an expedited (fast) external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. Additionally, if Tufts Health Plan has not met all of our major procedural requirements (as listed above under internal appeals) for matters subject to external review, you can immediately file an external appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the Plan.

If You Have Questions
If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department at 800-870-9488 for assistance.

Limitation on Actions

Limitation on Actions:
You cannot file a lawsuit against Tufts Health Plan for failing to pay or arrange for Covered Services unless you have completed our Member Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this Description of Benefits, you must first complete our Member Satisfaction Process, and then file your lawsuit within the next two years after the date you were first sent a notice of the denial. Going through the Member Satisfaction Process does not extend the time limit for filing a lawsuit beyond the two years after the date you were first denied coverage.

Chapter 6: Other Plan Provisions

Subrogation and Right of Recovery

The provisions of this section apply to all current and former plan participants. This Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representatives or administrators of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury, including, but not limited to, wrongful death, survival, or survivorship claims brought on your, your estate's, or your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" and "your" includes anyone on whose behalf the Plan pays benefits. No Member hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness, or condition for which the Plan has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners' medical payments coverage, premises or homeowners' insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interests are fully satisfied.

Subrogation
The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the plan are conditioned upon your agreement to reimburse the plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any Provider), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation and Right of Recovery, continued

Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan, including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Subrogation Agent
Tufts Health Plan administers subrogation recoveries for the Plan and may contract with a third party to administer subrogation recoveries for the Plan. In such case, that subcontractor will act as Tufts Health Plan's agent.

Assignment
In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the Plan provided or purports to allocate any portion of such settlement or judgment to payments of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the Plan or its representatives notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the Plan, Tufts Health Plan or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or

Subrogation and Right of Recovery, continued

failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until:

- the Plan is reimbursed in full,
- termination of your health benefits, or
- the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Workers' Compensation
Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The Plan will not provide coverage for any injury or illness for which it determines that the Member is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the Plan pays for the costs of health care services or medications for any work-related illness or injury, the Plan has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the Provider. If your Provider bills services or medications to the Plan for any work-related illness or injury, please contact the Tufts Health Plan Liability to Recovery Department at 1-888-880-8699, x. 21098.

Future Benefits
If you fail to cooperate with and reimburse the Plan, the health plan may deny any future benefit payments on any other claim made by your until the plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Coordination of Benefits

Benefits under Other Plans:
You may have benefits under other plans for Hospital, medical, dental or other health care expenses.

The Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for Covered Services with benefits payable by other plans, consistent with state law.

Primary and Secondary Plans:
The Plan will coordinate benefits by determining:

- which plan has to pay first when you make a claim; and
- which plan has to pay second.

We will make these determinations according to applicable state law.

Right to Receive and Release Necessary Information:
When you enroll, you must include information on your membership application about other health coverage you have.

After you enroll, you must notify us of new coverage or termination of other coverage. We may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the Plan's COB program.

Right to recover overpayment:
The Plan may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The Plan will recover only overpayments actually made.

For more information:
For more information about COB, call Member Services: 800-870-9488.

Use and Disclosure of Medical Information

We mail a separate "Notice of Privacy Practices" to all Members to explain how we use and disclose your medical information. If you have questions or would like another copy of our "Notice of Privacy Practices", call Member Services: 800-870-9488. Information is also available on our Web site at: **www.tuftshealthplan.com/gic**

Coverage for Pre-existing Conditions

Your coverage under this Description of Benefits is **not** limited with respect to pre-existing conditions. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before your Effective Date.

Circumstances Beyond Tufts Health Plan's Reasonable Control

Circumstances Beyond our Reasonable Control:
We shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond our reasonable control. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of Providers.

Group Contract

Acceptance of the Terms of the Group Contract:
By signing and returning the membership application form, you apply for Group coverage and agree to all the terms and conditions of the Group Contract, including this Description of Benefits.

Payments for Coverage:
The Plan under which you are covered is a self-funded plan. This means that the Group Insurance Commission is responsible for funding Covered Services for Members in accordance with the terms of the Plan. Under an administrative services agreement between the GIC and Tufts Health Plan, we processes claims, disburses Plan funds and provides other Covered Services only when the GIC has forwarded adequate funds to us to pay for Covered Services. This is the case even if the Plan has charged you for some or all of the cost of coverage under the Plan. If the GIC fails to provide adequate funds for claims payment, we have no responsibility to pay claims.

Changes to This Description of Benefits:
The GIC may change this Plan and this Description of Benefits in accordance with the terms of the Plan. Revisions do not require the consent of Members. Notice of Tufts Health Plan's revisions will be sent to the GIC and will include the effective date of the revision. The GIC is responsible for notifying the Members of revisions. We are not responsible if the GIC does not so notify Members. Any revisions will apply to all Members covered under the Plan on the effective date of the revision.

Notice:
Notice to Members: When we send a notice to you, it will be sent to your last address on file with us.

Notice to us: Members should address all correspondence to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193.

Enforcement of Terms:
We may choose to waive certain terms of the Description of Benefits, if applicable. This does not mean that we give up its rights to enforce those terms in the future.

When this Description of Benefits is Issued and Effective:
This Description of Benefits is issued and effective the Anniversary Date on or after July 1, 2018, and supersedes all previous Description of Benefits.

Terms and Definitions

This section defines the terms used in this Description of Benefits

Accident
Injury or injuries for which benefits are provided means accidental bodily injury sustained by the Member which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while his or her coverage is in force under this plan.

Note:
Injuries shall not include injuries for which benefits are provided or available under:

- any workers' compensation, employer's liability or similar law;
- motor vehicle no-fault plan;
- or other motor vehicle insurance-related plan; unless prohibited by law.

Allowed Charge
The expense used to determine payment of Plan benefits listed in this Description of Benefits.

- For a service eligible for coverage under Medicare: This means the payment amount Medicare establishes for that service. See your Medicare handbook, or contact Medicare, for more information.
- For a service that qualifies as a Covered Service under this Plan **only**: This means the Provider's actual charge for that service.

Ambulatory Surgery
Any surgical procedure(s) in an operating room under anesthesia for which the Member is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day, or in some instances, within twenty-four hours. For Hospital census purposes, the Member is an Outpatient not an Inpatient. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."

Anniversary Date
The date upon which the Group Contract first becomes effective and each successive annual renewal date.

Annual Enrollment Period
The period each year when eligible persons are allowed to apply for coverage under the Plan.

Benefit Period

- A Benefit Period **begins** the day you receive Covered Inpatient Services in a Hospital or Skilled Nursing Facility.
- The Benefit Period **ends** when you have not received Covered Inpatient Services in a Hospital or skilled nursing care for 60 days in a row.
- If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins.
- You must pay the Inpatient Hospital Deductible for each Benefit Period.

There is no limit to the number of Benefit Periods you can have.

Board-Certified Behavior Analyst (BCBA).
A Board-Certified Behavior Analyst (BCBA) meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for Members with diagnoses of autism spectrum disorders. BCBAs may supervise the work of Board-Certified Assistant Behavior Analysts and other Paraprofessionals who implement behavior analytic interventions.

Description of Benefits
This document, and any future amendments, which describes the Plan in which you have enrolled. This Description of Benefits is the agreement for the coverage under the Plan between the Group Insurance Commission and Tufts Health Plan.

Coinsurance
An amount you must pay as your share of the cost of Medicare Covered Services after you pay any Medicare Deductibles. Coinsurance is usually a percentage (for example, 20%), rather than a set amount.

Covered Services
The services and supplies for which the Plan will pay under this Description of Benefits must be:

- described in Chapter 3;
- for Medicare-approved services, obtained by a Provider who accepts assignment from Medicare; and
- except for preventive care, Medically Necessary.

Note: Covered Services do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any Provider, Member, service, supply, or medication.

Custodial Care

- Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care given primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute Hospital level of care;
- Services that could be given by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or
- adult and pediatric day care.
- In cases of mental health care when no other aspects of treatment require an acute Hospital level of care, Inpatient care given primarily:
    - for maintaining the Member's or anyone else's safety, or
    - for the maintenance and monitoring of an established treatment program,

Note: Custodial Care is not covered by the Plan.

Deductible
The amount you must pay for health care, before Medicare begins to pay for Medicare covered services. There is a Deductible for each Benefit Period for Part A, and each year for Part B. These amounts can change every year.

Durable Medical Equipment
Devices or instruments of a durable nature that:

- are reasonable and necessary to sustain a minimum threshold of independent daily living;
- are made primarily to serve a medical purpose;
- are not useful in the absence of illness or injury;
- can withstand repeated use; and
- can be used in the home.

Effective Date
This is the date which according to the Plan's records you become a Member and are first eligible for Covered Services.

Emergency
An illness or medical condition, whether physical, behavioral, related to substance abuse, or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- serious jeopardy to the physical and / or mental health of a Member or another person (or with respect to a pregnant Member, the Member's or her unborn child's physical and / or mental health);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another Hospital before delivery, or a threat to the safety of the Member or her unborn child in the event of transfer to another Hospital before delivery.

Some examples of illnesses or medical conditions requiring Emergency care are: severe pain; a broken leg; loss of consciousness; vomiting blood; chest pain; difficulty breathing; or any medical condition that is quickly getting much worse.

Experimental or Investigative
A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered Experimental or Investigative and therefore, not Medically Necessary, if any of the following is true:

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or
- reliable scientific evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
- evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined;
- the peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled, or cohort studies, or there are few or no well-designed randomized, controlled trials;
- there is no scientific or clinical evidence that the treatment is at least as beneficial as any established, evidence-based alternatives.

Group Insurance Commission (GIC)
The Massachusetts state agency that provides health insurance for state and Participating Municipality retired employees and their eligible Dependents

Group Contract
The agreement between Tufts Health Plan and the Group Insurance Commission under which we agree to provide certain administrative services and the GIC agrees to pay us for these services. The Group Contract includes this Description of Benefits and any documents.

Hospital
A hospital, as defined by Medicare, which is authorized for payment by Medicare and licensed to operate as a hospital in the state where it operates.

Individual Coverage
Coverage for Member only.

Inpatient
A patient who is:
- admitted to a Hospital or other facility licensed to provide continuous care; and
- classified as an Inpatient for all or a part of the day.

Medically Necessary

- **For a service eligible for coverage under Medicare:** This means "medically necessary" as determined by Medicare. See your Medicare handbook or contact Medicare for more information.
- **For a service that qualifies as a Covered Service under this Tufts Medicare Complement Plan Description of Benefits only:** This term has the following meaning:
  A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:
  - Is the most appropriate available supply or level of services for the Member in question considering potential benefits and harms to that individual;
  - Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
  - for services and interventions not in widespread use, is based on scientific evidence.

  In determining coverage for Medically Necessary Services, Tufts Health Plan uses Medical Necessity Guidelines which are:
  - developed with input from practicing physicians;
  - developed in accordance with the standards adopted by national accreditation organizations;
  - updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
  - evidence-based, if practicable.

Medicare
Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare-approved Amount
The amount a Physician or supplier that accepts assignment can be paid by Medicare.

- It includes what Medicare pays and any Deductible, Coinsurance, or Copayment that you pay.
- It may be less than the actual amount a doctor or supplier charges.

Medicare Eligible Expenses
Expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Member
A person who is covered under the Plan and therefore entitled to all benefits in accordance with the Plan. Also referred to as "you".

Mental Disorders
Psychiatric illnesses or diseases listed as Mental Disorders in the latest edition, at the time treatment is given, of the American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders regardless of whether the cause of the illness or disease is organic.

Non-Conventional Medicine
A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the Tufts Health Plan definition of Medical Necessity and are not covered. Providers of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in connection with a traditional office visit. Providers of Non-Convention Medicine services often request payment up front because health insurance typically does not cover these services.

Common terminology used to refer to these types of services include, but are not limited to, “alternative medicine”, “complementary medicine”, “integrative medicine”, “functional health medicine”, and may be described as treating “the whole person”, “the entire individual”, or “the inner self”, and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of Non-Conventional Medicine and related services include, but are not limited to:

- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- whole medicine systems (e.g., naturopathy, homeopathy);
- biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- other related practices when provided in connection with Non-Conventional Medicine services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

Outpatient

A patient who receives care that is not provided on an Inpatient basis. This includes services provided in:

- a physician's office;
- an Ambulatory Surgical Center; and
- an Emergency room or Outpatient clinic.

Paraprofessional

As it pertains to the treatment of autism and autism spectrum disorders, a Paraprofessional is an individual who performs applied behavior analysis (ABA) services under the supervision of a Board-Certified Behavior Analyst (BCBA).

Physician

As defined by Medicare, an individual licensed under state law to practice:

- medicine; or
- osteopathy.

Participating Municipality

A city, town or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the Group Insurance Commission.

Plan

Tufts Medicare Complement Plan, the Group Insurance Commission's self-funded plan administered by Tufts Health Plan, which provides you with the benefits described in this Description of Benefits.

Provider

A health care professional or facility licensed in accordance with applicable law. Providers do not have to contract with Tufts Health Plan in order to offer services for the benefits listed in this Description of Benefits.

The types of Providers covered under the Plan include, but are not limited to: Ambulatory Surgical centers; Hospitals; physicians; physician assistants; certified nurse midwives; certified registered nurse anesthetists; nurse practitioners; optometrists; podiatrists; psychologists; licensed mental health counselors; licensed independent clinical social workers; licensed drug and alcohol counselor I and Skilled Nursing Facilities.

The Plan will only cover services of a Provider, if those services are:

- listed as Covered Services; and
- within the scope of the Provider's license.

<u>Important Note – Providers outside of Massachusetts:</u>

No coverage is available under this Plan for services obtained by the following types of Providers **outside of Massachusetts**:

- clinical specialists in psychiatric and mental health nursing;
- licensed independent clinical social workers (for Covered Services under this Plan only);
- licensed mental health counselors; and
- psychologists (for Covered Services under this Plan only).

Reserve Days
Sixty days that Medicare will pay for when you are put in a Hospital for more than 90 days of Medicare covered services. These 60 Reserve Days can be used only once during your lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily Coinsurance amount.

Sickness
An illness or disease of a Member for which expenses are incurred after the Effective Date and while the insurance is in force.

Note: Sicknesses shall not include sicknesses for which benefits are provided or available under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, or other motor vehicle insurance-related plan, unless prohibited by law.

Skilled
A type of care which is Medically Necessary and must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.

Skilled Nursing Facility
A Medicare-certified Skilled Nursing Facility with the staff and equipment to provide: skilled nursing care and/or skilled rehabilitation services; and other related health services.

Tufts Health Plan or Tufts HP.
Tufts Benefit Administrators, Inc., a Massachusetts corporation d/b/a Tufts Health Plan. Tufts HP does not insure this Tufts Medicare Complement Plan offered by the GIC. Also referred to as: "we;" "us;" or "our."

Urgent Care
Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are: a broken or dislocated toe; a cut that needs stitches but is not actively bleeding; sudden extreme anxiety; or symptoms of a urinary tract infection.

Note: Care is not considered Urgent Care if it is rendered:
- after the Urgent condition has been treated and stabilized;
- and the Member is safe for transport.

PART II:

Prescription Drug Benefit Plan

Administered by

SilverScript®

SilverScript Employer PDP-sponsored by the Group Insurance Commission

A Medicare Prescription Drug Plan (PDP) offer by SilverScript®
Insurance Company with a Medicare Contract

For questions about any of the information in Part II of this Description of Benefits,
Please contact SilverScript at 877-876-7214.

Prescription Drug Plan

Section I – Introduction

SilverScript Employer PDP sponsored by the Group Insurance Commission (SilverScript) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. "Employer PDP" means that the plan is an employer-provided Prescription Drug Plan. The Plan is offered by SilverScript® Insurance Company which is affiliated with CVS Caremark®, the GIC's pharmacy benefit manager for UniCare State Indemnity Plan members.

This handbook gives you a summary of what SilverScript covers and what you pay. It does not list every service that SilverScript covers or list every limitation or exclusion. To get a complete list of services, call SilverScript and ask for the *Evidence of Coverage*.

You have choices about how to get your Medicare prescription drug benefits
As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options:

- **SilverScript Employer PDP sponsored by the Group Insurance Commission** as the prescription drug coverage for members of UniCare State Indemnity Plan/Medicare Extension
- One of the GIC's other Medicare plans

You make the choice. However, **if you decide to enroll in Medicare Extension but choose <u>not</u> to be enrolled in or are disenrolled from SilverScript Employer PDP sponsored by the GIC, you will lose your GIC medical, prescription drug and behavioral health coverage.**

Information in this handbook

- Things to Know About SilverScript
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

Things to Know About SilverScript

SilverScript Phone Numbers and Website

- Call toll free 877-876-7214. TTY users should call 711.
- Website: <u>gic.silverscript.com</u>.

Hours of Operation

You can call SilverScript 24 hours a day, 7 days a week.

Who can join?

To join SilverScript, you must

- ❑ Be eligible for Medicare Part A for free, and enrolled in Medicare Part B, and
- ❑ Be a United States citizen or are lawfully present in the United States, and
- ❑ Live in our service area which is the United States and its territories, and
- ❑ Meet any additional requirements established by the GIC.

Which drugs are covered?

The plan will send you a list of commonly used prescription drugs selected by SilverScript and **covered under the Medicare Part D portion of the plan**. This list of drugs is called a *Formulary*. You may review the complete plan formulary and any restrictions on the website at gic.silverscript.com. Or call SilverScript and you will be sent a copy of the formulary. This formulary does not include drugs covered through the additional coverage provided by the GIC.

The formulary may change throughout the year. Drugs may be added, removed or restrictions may be added or changed. These restrictions include:

- **Quantity Limits (QL)** – For certain drugs, SilverScript limits the amount of the drug that it will cover.
- **Prior Authorization (PA)** – SilverScript requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before we fill your prescription. If you don't get approval, SilverScript will not cover the drug.
- **Step Therapy (ST)** – In some cases, SilverScript requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, SilverScript will not cover Drug B unless you try Drug A first. If Drug A does not work for you, SilverScript will then cover Drug B.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers:

- **Generic drugs (Tier 1)** – most cost effective drugs to buy. The active ingredients in generic drugs are exactly the same as the active ingredients in brand drugs whose patents have expired. They are required by the Food and Drug Administration (FDA) to be as safe and effective as the brand drug.
- **Preferred Brand drugs (Tier 2)** – brand drugs that do not have a generic equivalent and are included on a preferred drug list. They are usually available at a lower cost than Non-Preferred Brand drugs.
- **Non-Preferred Brand drugs (Tier 3)** – brand drugs that are not on a preferred drug list and usually are a high cost. Certain drugs are limited to a 30 day supply. These drugs have "NDS" (for "Non-Extended Day Supply") next to the drug name in the formulary.

You will need to use your formulary to find out the tier for your drug or if there are any restrictions on your drug, as well as to determine your cost. The amount you pay depends on the drug's tier and whether you are in the Initial Coverage, Coverage Gap or Catastrophic Coverage stage. If the actual cost of a drug is less than your normal copay for that drug, you will pay the actual cost, not the higher copay amount.

Additional drugs covered by the GIC

The GIC provides additional coverage to cover drugs that are not included on the SilverScript formulary, as well as certain drugs not covered under Medicare Part D, such as:

- ❑ Prescription drugs when used for anorexia, weight loss or weight gain
- ❑ Prescription drugs when used for the symptomatic relief of cough or cold
- ❑ Prescription vitamins and mineral products not covered by Part D
- ❑ Prescription drugs when used for treatment of sexual or erectile dysfunction
- ❑ Certain diabetic drugs and supplies not covered by Part D
- ❑ Prescription drugs for tobacco cessation
- ❑ Part B products, such as oral chemotherapy agents

These drugs are not subject to SilverScript appeals and exceptions process and the cost of these drugs will not count towards your Medicare out-of-pocket costs or Medicare total drug costs. There may be other drugs covered by the additional coverage from the GIC. Contact SilverScript for details.

Drugs used to treat opioid use disorder
Generic drugs used to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) are covered with no copayment or prior authorization.

Which pharmacies can I use?
The plan has a network of pharmacies, including retail, mail-order, long-term care and home infusion pharmacies. You must use a SilverScript network pharmacy, unless it is an emergency or non-routine circumstance.

SilverScript has **preferred** network retail pharmacies where you can get up to a 90-day supply of your maintenance medications for the same copay as mail order. You will also be able to get up to a 90-day supply of your maintenance medication at **non-preferred** network retail pharmacies, but the copay will be three times the retail 30-day supply copay.

The pharmacies in SilverScript's network can change at any time. To find a preferred or non-preferred network pharmacy near your home or where you are traveling in the United States or its territories, use the pharmacy locator tool on the website at gic.silverscript.com or call SilverScript at 877-876-7214, 24 hours a day, 7 days a week. TTY users should call 711.

You may use an out-of-network pharmacy only in an emergency or non-routine circumstance. If you use an out-of-network pharmacy, you may be required to pay the full cost of the drug at the pharmacy. In this case, you must complete a paper claim and send it to SilverScript to request reimbursement. You are responsible for your copay and will be reimbursed the plan's share of the cost.

If you may need to get your prescription filled while you are traveling outside the country, contact SilverScript Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 8747, Boston, MA 02114.

Claim forms are available at gic.silverscript.com or by calling 877-876-7214.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Section II – Summary of Benefits

How Medicare Part D Stages Work

The **standard Medicare Part D plan** has four stages or benefit levels. This is how these stages work in 2018:

Table 1. How Medicare Part D Stages Work

Stage	Standard Medicare Part D Plan without your additional coverage provided by the GIC	SilverScript with your additional coverage provided by the GIC This is what you pay
Deductible	$ 405	$ 0
Initial Coverage	After meeting the deductible, a person pays 25% of the drug cost until he reaches $3,750 in total drug costs	Since you have no deductible, you start in this stage and pay your GIC copay.
Coverage Gap	Also called the "donut hole," this is when a person pays a large portion of the cost, either ▪ 35% brand-name drug cost ▪ 44% generic drug cost	You continue to pay only your GIC copay.
Catastrophic Coverage	After you reach $5,000 in Medicare Part D out-of-pocket costs, a person pays the **greater of**: ▪ 5% of the drug cost, or ▪ $3.35 for generic drugs ▪ $8.35 for brand-name drugs	After you reach $5,000 in Medicare Part D out-of-pocket costs, you pay the **lower of**: ▪ Your GIC copay, *or* ▪ The Medicare Catastrophic Coverage cost-share, the greater of ▪ 5% of the drug cost, or ▪ $3.35 for generic drugs ▪ $8.35 for brand-name drugs

In calendar year 2018 the standard Medicare Part D plan maximum out-of-pocket expense of $5,000 includes the deductible, any amount you have paid for your copay, any amount you have paid during the coverage gap, any manufacturer discounts on your brand-name drugs in the coverage gap, and any amount paid by Extra Help or other governmental or assistance organizations on your behalf.

Medicare's maximum out-of-pocket cost does not include the monthly premium, if any, the cost of any prescription drugs not covered by Medicare, any amount paid by SilverScript, or any amount paid through the additional coverage provided by the GIC.

Please note: Standard Medicare Part D stages and plan changes can occur every year. For further information, please visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For plan changes, please call SilverScript Customer Care at 1-877-876-7214, 24 hours a day, 7 days a week or visit gic.silverscript.com. TTY users should call 711.

Your Prescription Drug Benefits – Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

	SilverScript
How much is the monthly premium?	There is no separate prescription drug premium. This benefit is provided as part of your medical coverage. If you have any questions about your premium, contact the GIC's Public Information Unit at 617-727-2310, ext. 1 (TTY users: Relay Service 711); available 8:45 a.m. to 5:00 p.m., Monday through Friday.

If your individual income is over $85,000, or if your income is over $170,000 and you are married filing your taxes jointly, you will be required to pay an income-related additional monthly premium to the federal government in order to maintain your Medicare prescription drug coverage. This premium is adjusted based on your income.

You will receive a letter from Social Security letting you know if you have to pay this extra amount. This letter will explain how they determined the amount you must pay and the actual Income Related Monthly Adjustment Amount (IRMAA).

If you are responsible for an additional premium, the extra amount will be deducted automatically from your Social Security check. If your Social Security check is not enough to cover the additional premium, Medicare will send you a bill. You do not pay this amount to the GIC or SilverScript. You send your payment to Medicare.

For more information about the withholdings from your check, visit ssa.gov/medicare/mediinfo.html, call 800-772-1213, 7 a.m. to 7 p.m., Monday through Friday, or visit your local Social Security office. TTY users should call 800-325-0778.

For more information about Part D premiums based on income, call Medicare at 800-MEDICARE (800-633-4227).

	SilverScript
How much is the deductible?	This plan does not have a deductible.

	SilverScript
Initial Coverage	You pay the amounts below until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs for Part D drugs paid by both you and the plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Some of our network pharmacies are preferred network retail pharmacies. You pay the same as mail order for a 90-day supply of a maintenance medication at **preferred** network retail pharmacies.

	SilverScript		
	Up to a 30-day supply at a retail network pharmacy	**Up to a 90-day supply at a preferred retail network pharmacy**	**Up to a 90-day supply at a non-preferred retail network pharmacy**
Tier 1 Generic	$10	$25	$30
Tier 2 Preferred Brand	$30	$75	$90
Tier 3 Non-Preferred Brand	$65	$165*	$195*

	SilverScript
	Up to a 90-day supply through the mail order pharmacy
Tier 1 Generic	$25
Tier 2 Preferred Brand	$75
Tier 3 Non-Preferred Brand	$165*

	SilverScript
	Up to a 34-day supply at a long-term care (LTC) facility
Tier 1 Generic	$10
Tier 2 Preferred Brand	$30
Tier 3 Non-Preferred Brand	$65*

* Certain drugs are limited to a 30 day supply. These drugs have "**NDS"** next to them in the formulary.

	SilverScript
Coverage Gap	Due to the additional coverage provided by the GIC, you pay the same copay that you paid during the Initial Coverage stage. You will see no change in your copay until you qualify for Catastrophic Coverage.

	SilverScript

Catastrophic Coverage	After you reach $5,000 in Medicare out-of-pocket drug costs for the year, you pay the **lower** of:
	▪ Your GIC copay, or
	▪ Medicare's Catastrophic Coverage, which is the **greater** of
	  ▪ 5% of the cost, or
	  ▪ $3.35 copay for generic, including brand drugs treated as generic, or
	  ▪ $8.35 copay for all other drugs

Multi-Language Insert

ENGLISH
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Customer Care at the number on your member ID card.

SPANISH
ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al Cuidado al Cliente al teléfono indicado en su tarjeta de membresía.

CHINESE
小贴士：**如果您**说普通话，欢迎使用免费语言协助服务。请拨**打会**员卡上的客户服务电话。

VIETNAMESE
CHÚ Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Hãy gọi cho bộ phận Chăm sóc Khách hàng theo số điện thoại ghi trên thẻ hội viên của quý vị.

KOREAN
알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. 멤버쉽 카드에 있는 고객 지원센터로 연락 주시기 바랍니다.

TAGALOG
PANSININ: Kung nagsasalita po kayo ng Tagalog, magagamit ninyo ang mga serbisyong tulong sa wika ng walang bayad. Tawagan po ninyo ang Customer Care sa numero na nasa inyong kard bilang kasapi.

RUSSIAN
ВНИМАНИЕ: Если вы говорите по-русски, вам будут бесплатно предоставлены услуги переводчика. Звоните по номеру телефона, указанному на вашей членской карточке.

ARABIC
ملاحظة: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية مجانًا من أجلك. اتصل برقم رعاية العملاء المبين على بطاقة عضويتك.

FRENCH CREOLE
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Kliyan nan nimewo ki make sou kat manm ou an.

FRENCH
ATTENTION: Si vous parlez français, des services gratuits d'interprétation sont à votre disposition. Appelez le Service client au numéro figurant sur votre carte de membre.

POLISH
UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń na numer Obsługi Klienta podany na Twojej karcie członkowskiej.

PORTUGUESE
ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Ligue para o atendimento ao cliente no número impresso no cartão de filiação.

ITALIAN
ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami l'Assistenza Clienti al numero indicato sulla sua tessera di iscrizione.

JAPANESE
お知らせ:日本語での対応を望まれる方には、無料で通訳サービスをご利用になれます。メンバーカードの裏側に記されている電話番号までお問い合わせください。

GERMAN
BITTE BEACHTEN: Wenn Sie Deutsch sprechen, stehen Ihnen unsere Dolmetscher kostenlos zur Verfügung. Rufen Sie Kundenbetreuung unter der Telefonnummer auf Ihrer Mitgliedskarte an.

FARSI
توجه: چنانچه به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، به صورت رایگان، در اختیار شما قرار خواهد گرفت. از طریق شماره روی کارت عضویت خود با بخش رسیدگی به مشتریان تماس بگیرید.

GROUP INSURANCE COMMISSION NOTICES

FOR SUBSCRIBERS
ENROLLED IN TUFTS MEDICARE
COMPLEMENT PLAN

The Commonwealth of Massachusetts

Group Insurance Commission

P.O. Box 8747
Boston, Massachusetts 02114

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.
You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

*If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverag**e. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.***

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws**;**
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator.

When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at **mass.gov/gic**.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310, ext. 1 or TTY for the deaf and hard of hearing at 617-227-8583.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you and/or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or visit **tuftshealthplan.com**.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need prior authorization from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or visit **tuftshealthplan.com**.

ANTI-DISCRIMINATION NOTICE

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

tuftshealthplan.com | 800.462.0224

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

800.870.9488

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS
Health Plan

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 800.870.9488

tuftshealthplan.com

Offered by Tufts Benefit Administrators, Inc.

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